COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER

COMMUNITY REFERRAL – SEATING CENTER (PT)

Date Referred:
Date Rec'd:

Does this patient have a Rancho #?
☐ NO ☐ Yes, Number:

Patient Name:		DOB:
Phone Day: ( )	Phone Cellular: ( )	Contact Person Name:

☐ **SEATING CENTER (Physical Therapy):**	**Appointment Date/Time:**

Order Item: PT SEAT CENTER COM

Evaluate, Develop Treatment Plan and Treat to address problems related to:

DIAGNOSIS (Required): **ONSET DATE:**

RELEVANT MEDICAL HISTORY:

PRECAUTIONS (Required)

PRIORITY: ☐ Urgent (ASAP) ☐ Routine

REASON FOR REFERRAL (Choose ONE only):
☐ Cushion Evaluation ☐ New Wheelchair / Seating System Evaluation ☐ Fitting Clinic

TO ADDRESS PROBLEMS RELATED TO:
☐ New Manual Wheelchair ☐ New Power Mobility Device/ Wheelchair ☐ New Seating System
☐ New Cushion / Pressure Sores ☐ Wheelchair Modifications / Adjustments (to correct posture or discomfort)

FOR NEW WHEELCHAIR EVALUATION REFERRAL (REQUIRED), SPECIFY:
Date of Face to Face Examination:_____ Length of Need for Wheelchair: ☐ **Temporary** Need ☐ **Lifetime** Need
* Copy of Face to Face Examination Documentation is required and must accompany this referral.

COMMENTS:

Medical Provider Information:

REFERRING PROVIDER NAME (Please Print):		**PHONE #:**
ADDRESS		**FAX #:**
LICENSE #:	**NPI #:**	**EMAIL:**

REFERRING PROVIDER SIGNATURE	**DATE**

*** Please return this form and the Patient Information form to:**
Rancho Outpatient Referral Office
Telephone: (562) 401-6536 Fax: (562) 401-7604
Email: SeatingCenter@dhs.lacounty.gov (please send encrypted)

MRUN

NAME

DOB/GENDER

T-R0775EPTDI

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